Health Care Cost Trends Hearings

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Seena Perumal Carrington

Thank you all for joining us, and I welcome you to the Division's public hearings on health care cost trends. I'm Seena Perumal Carrington, Acting Commissioner of the Massachusetts Division of Health Care Finance and Policy, and chair of these hearings. I am joined today by three key partners, Assistant Attorney General Tom O'Brien, who is also Chief of the Health Care Division, Commissioner Joe Murphy from the Division of Insurance, and Commissioner John Auerbach from the Department of Public Health, as well as several key officials, Chairman Sanchez, Secretary JudyAnn Bigby, Attorney General Martha Coakley, and Chairman Moore.

I would like to begin by discussing the role of the Division of Health Care Finance and Policy for those of you who may be less familiar with our work. We collect a broad and diverse array of data from across the Massachusetts health care landscape. We produce trusted, reliable analysis. Our work already spans many key health care issues, but we are always looking to explore new

topics. Think of us as a think tank, trying to demystify the Commonwealth's health care delivery system in order to identify strategies to increase its efficiency. In keeping with that mission, the legislature directed the Division in 2008 to issue reports on health care cost trends, and to then hold public hearings to identify strategies and determine the best course forward, with action-oriented solutions. This week's hearings bring together an impressive array of key health care stakeholders, providers, insurers, employers, consumers, and experts, in order to ultimately identify long-term solutions that will contain health care costs in the Commonwealth. It is my intention, and the intention of my partners from DOI, DPH, and the Attorney General's Office, to have these hearings uncover different and perhaps conflicting perspectives on what's driving the rise in health care costs, and what can be done, both by public policy and industry practice, to contain it. While there are no easy solutions or answers to this intensifying challenges, these hearings represent an opportunity to have frank, open discussions. Now is the time to put your cards on the table and show your hand, or we will never make progress. For all of our sakes, I hope that the theme of next year's hearings are not that, once again, health care costs are growing at an unsustainable rate.

Specifically, the hearings begin today with a discussion of health care cost trends, and the factors underlying their growth. Over the next three days, we will dig deeper into the challenges confronting the health care delivery system. We will explore progress made to date by existing public and private efforts, and we will discuss opportunities for further innovation, within the framework of five topical categories. First, variation in provider prices. Second, alternate payment methodologies. Third, health resource planning. Fourth, integration and care coordination. Fifth, the goal of government and market in reducing health care costs. Health Care for All jokingly refers to these hearings as health care finance boot camp, and in a way, it is. I can't help but agree. I hope, by the end of these hearings, at the end of this week, you leave feeling better informed, feeling that your viewpoints were heard, and feeling, most importantly, that we need to collectively take action. For those of you who may have visited the agency's website in recent weeks, you will have noticed our countdown clock, ticking down the days, hours, and minutes to the second annual hearings. For us at the Division, it started as a way to drum up interest in what could otherwise be viewed as a wonky affair. But over the last several days, the countdown became our dreaded enemy, serving as a constant reminder that these hearings would be soon upon us, and that we

needed to be ready. If you go to our website now, it says the hearings are in progress, and that is because of the tireless, nearly Herculean efforts of many. Notes of gratitude are typically saved for the end, but some traditions are better broken. I have the pleasure and privilege of working each day with individuals who make me feel challenged and humbled by their energy, commitment, and tireless dedication to public service. While every member of the Division team played a role in making these hearings possible, I want to specifically acknowledge a few. Stacey Eccleston, Assistant Commissioner of Health Research and Policy, Jordan Coriza, Director of External Affairs, Harry [Lohr], Director of Administration, Steve McCabe, Assistant Commissioner for Health Care Finance, Elaine Goldman, Michael [Grenier], Leanne Hastings, [Char Kasprzak], Ariel Klein, Alex [Ley], Janelle Liceaga, Rick [Vogel], and our partners at the Office of the Attorney General. Thank you. We wouldn't have been here without all of your work. I also want to thank Bunker Hill Community College for hosting us and providing us with such great space for this public dialogue.

Before we begin, I will quickly review the day's agenda. We will start today with brief comments from several key state officials. Following their thoughts, we will hear from two of the experts who helped conduct the research analysis for the

Division’s reports on health care cost trends. Next, we will hear from the Division of Insurance regarding their activities and efforts related to Chapter 288 of the acts of 2010. We will then be joined by Governor Deval Patrick. After his remarks, there will be a brief 45-minute lunch break. Both the cafeteria and café, by the way, are located on the first floor. We will promptly begin again at 1:15, with a presentation by the Attorney General. Her presentation will be followed by testimony from the public. If you’re interested in providing comments, please sign up to do so at the registration table. Hopefully, if we stay on schedule, we can end today before 5 P.M. But these hearings, I want to emphasize, are about more than just listening. I encourage all of you to engage with the ideas and information being presented. There are index cards available in each of your folders. Please write any questions that you may have, and members of my team will be walking around. At the end of each presentation on analytical findings, I will ask some of these submitted questions. At this time, then, I would like to officially begin by inviting Chairman Moore, whose leadership on health care issues, has served as a key driver for these hearings, to speak. Thank you, Chairman.

Richard T. Moore

Thank you very much, Commissioner. I'm pleased to join with you this morning and this opportunity to offer remarks as we in the legislature, and more specifically the health care finance committee, continue to forge ahead with further comprehensive reform of the delivery system. Along with my able co-chairman, Representative Steven Walsh, and our colleagues on the committee, currently engaged in statewide hearings on House Bill 1849, an act improving the quality of health care and controlling cost by reforming health systems and payments. This important legislation, filed by the Governor, aims to promote movement toward global payments and away from fee-for-service provider payments, based on a unanimous recommendation of the special commission on payment reform. The health care finance committee legislative hearings, combined with the recent reports of your division, and the Attorney General, as well as the ongoing work of the special commission on provider price reform, will serve as important resources for us as we begin refining what promises to be one of the most complex reforms we've seen since undertaking the effort to expand access to safe, affordable, high-quality health care with the passage of Chapter 58 of the acts of 2006.

Concerns about the rising cost of health care and the essential need for all care to be the right care, delivered at the right time and in the right place, arose long before the passage of our landmark health reform. Chapter 58 of the acts of 2006, Chapter 305 of the acts of 2008, and Chapter 288 of the acts of 2010 all included major provisions aimed at bending the rising cost curve of health care costs, while simultaneously promoting the safety and quality of care, and of course ensuring access to care for nearly every resident of the Commonwealth. The next chapter must deliver this care at the right cost. Medical breakthroughs are occurring at a more rapid pace than ever before, and many of them are happening right here in the Bay State. While it's gratifying to be on the cutting edge of health care advancements, those who pay for health care, especially employers, consumers, and tax payers, often suffer from sticker shock when they see the bill. Our concern turns to outrage when we learn that there's no direct correlation between the cost of health care and the quality of care received. In fact, sometimes the most expensive health care turns out to be substandard or even dangerous.

As those in state government, stakeholders, and the public address the need for the very reform we're considering right now in the Committee on Health Care Financing, that discussion is

focused on containing the rising costs, or trying to keep the costs below the level of medical inflation. We've all heard the pleas, whether it was a young couple trying to find their infant appropriate treatment, or senior citizens struggling to prioritize needed medication or heating her home. We've heard the calls from businesses, especially small businesses, and their workers to keep premium increases to single digits. We've heard the demands of angry taxpayers to put an end to budget-busting health care costs. I've heard the pleas loud and clear. People are literally mad as hell, and they want us to do more than contain health care costs or bend the curve. They want us to break the curve. They want us to cut health costs while maintaining safe, high-quality care for every resident of Massachusetts. Clearly, there can be no real value in only seeking cost efficiencies if, by making cuts, we're going to jeopardize the quality of care. America tried that in the 1990s, and while largely arbitrary limits on care delivery kept costs from growing as fast, those limits could not be sustained. We can do better. The people of Massachusetts deserve better, and to the degree that Massachusetts may be seen as a national model, every American deserves better.

Any reform -- I repeat that -- any reform -- that the legislature ultimately makes to the delivery system must, in my

opinion, strive for better quality care, which should be a combination of improved clinical outcomes for patients, better coordination of care across payers and providers, recognition of the impact of behavioral health and patient compliance, reduction of the tendency to practice defensive medicine, and the implementation of an overall wellness strategy, to get and keep our population healthy. If this is to be our objective, then there's no doubt in my mind that significant cost savings will, in time, be the result. Many who followed our past reform efforts closely will know that addressing quality and cost are far from new concepts, but ones that have woven common threads throughout each chapter. Whether it was the establishment of the Quality and Cost Council, or the creation of the statewide Infection Prevention Program in Chapter 58, or the formation of the eHealth Institute and the prohibition of payments for never events, or hospital readmissions, in Chapter 305, improving the quality of health care has consistently been our primary objective. Our efforts continued last year with the passage of Chapter 288, which included standardized transparency measures for provider pricing, and an open enrollment period for Commonwealth Choice.

The success of many of these programs is, I believe, due in large part to the leadership of strongly committed and

knowledgeable parties, like Senate President Therese Murray, who's keenly aware of the fact that mere cost cutting is not a means to a quality end. Provisions for shrinking costs, or, at the very least, controlling them, there were key parts of earlier reforms that have been proven to work, but they must be nurtured and expanded. Health care cost reduction strategies, such as the work of the Quality and Cost Council, the Physician Tuition Assistance Program; screening to prevent more serious health consequences; academic detailing of prescription drugs; expansion of health information technology; deployment of telehealth systems; a strong, effective pharmaceutical marketing ethics law; the groundbreaking best practice reports of the Betsy Lehman Center; the publicly available reporting of the Infection Prevention Program; humane and sensitive end-of-life care reforms; real Determination of Need reforms; standardized bill coding and administrative simplification; these, which are all part of the earlier three chapters, and others, need to be fully implemented and consistently and adequately funded over many years. They cannot work if we eliminate them, cut their funding, or provide only limited, half-hearted budgetary, legislative, and administrative support.

Last year, I spoke at this very hearing and asked about the cost of inaction when considering proposals aimed at helping our

small businesses. We could not afford, I said last year, not to take action to move toward affordable health care. The Governor and the legislature took some important steps in that direction. However, there's much more to do. We must not settle for those initial steps, nor undermine our efforts by losing our resolve or failing to provide necessary resources. Today, however, I come bearing a different question. Are we prepared to invest in quality improvement to achieve payment and provider price reform and reduction? First, what's the cost to government? The bill filed by the Governor that's now before the Committee on Health Care Financing contains no specific appropriation. We pointed out to the administration that current state resources are not sufficient to implement such a massive shift in our delivery model. Last week, the administration agreed that there will be a need to increase budget support for the Division of Health Care Finance and Policy, the Department of Public Health, and the Division of Insurance, by up to $6.7 million and between 53-75 additional staff among those agencies. Past experience with such estimates suggest that these will be baseline estimates, and are likely to grow with more detailed analysis.

Any reform must have meaningful oversight to ensure the integrity of implementation. One that includes individuals nominated not for their allegiance to the appointing authority,

but for their expertise. The effort must be implemented by people who are specifically qualified to assume this significant responsibility. These experts should be afforded appropriate flexibility to ensure their reforms are free of politics and in the best interest of the taxpayers in our particular system. Their work, especially during the five or more transition years needed for implementation of payment and price reform, must not be distracted by other administrative responsibilities in state government, or their work undermined by budget cuts. Transition to a new payment system and pricing model is not only important to the improvement of our health care system, but to our entire economy, in view of the leading role that health care plays in our state's economy. We cannot expect to achieve such a significant reform of our payment model and health care pricing at a bargain rate. Such reform will require careful diagnosis, skillful surgery, perhaps a transplant, and extensive rehabilitation; not band-aids or placebos. There will be a need to invest in areas of government that provide oversight of the health care system, if they're to do more than impose largely arbitrary cost controls, such as setting limits on premium increases or rate setting of provider prices.

What is the cost to the health care system? The motivation for payment and price reform is to make sure that patients receive

better care. It seeks to maintain or improve health, thus resulting in lower systemic costs. As many of us suspected, and the Attorney General has now confirmed, global payments, or the establishment of accountable care organizations, will not realize their potential savings if we do not first, and simultaneously, confront the issue of market influence. Of equal concern must be the costs associated with the establishment of ACOs, especially considering the risk that's to be shifted from payer to provider. ACOs will require infrastructure cost, which hopefully include the expanded use of electronic medical records, but will also include reinsurance costs and data warehouses to manage claims. The administration, in its filing for the next 1115 Medicaid waiver, has suggested that there's a significant cost to establishing an ACO. They state that one large urban public health provider, which is well positioned to become an ACO, will need hundreds of millions of dollars in supplemental Medicaid payments to become a successful ACO pilot.

What will it cost to transition the rest of the providers into the ACO model, and who will pay for this new world? Will it be necessary to offer incentives in the form of higher reimbursements for those who will make global payments in order to offset the transition costs and the assumption of greater

risk? Will we ask payers to share in that cost as their own risk declines? How quickly can we expect any savings from fee-for-service to be enjoyed by those now paying for health care? What will these new ACO entities look like? Can the small group practice survive in this refined environment? Is the ACO model the Holy Grail of payment reform, or will we also value and support other payment methodologies? Must only larger entities have the resources to manage the risk they'll be assuming? If the entities will indeed be larger, either through mergers or contractual agreements, how does that contrast with our current model, where it seems price variation relies more on market power and reputation of the entity, as opposed to quality? Is bigger necessarily better in creating ACOs? Must all health care be provided through ACOs, or will some delivery models still utilize fee-for-service, and how should quality outcomes be evaluated and compensated by any model of care? Any thoughtful reform must incorporate these important considerations and make strides in accommodating appropriate flexibility. I believe it's at least my contention, and I think I share this with my house chair, what we will attempt to do as we further refine the legislation before us.

Furthermore, I think many would agree that we currently reward volume over quality. Sadly, our system spends far too much care

on health. That dynamic must change, and success will likely be achieved if the entire system makes sacrifices for the good of the whole. For too long, health care, despite its not-for-profit players, has run like a for-profit business, which often forfeits quality for larger margins, rarely viewing customers and patients as stakeholders. Should excess revenue, above what is appropriate for not-for-profit entity, be used for excessive salaries or major capital facilities, or for promoting the first kid on the block bragging rights for the latest technology, even when it does nothing to advance patient care or meet patient need? What reform should be considered? For starters, our system is too territorial. This resistance of competition often limits the infusion of creativity and ingenuity, and potentially limiting a patient's access, and most certainly preventing our ability to offer lower costs. Some are resistant to change because it might represent a smaller market share. We can clout for a certain sector, or force costs to diminish. That stubborn mindset is no longer acceptable, and I'm hopeful that all stakeholders would agree.

Secondly, insurance premiums are intended to pay for high-quality care when it's needed, not golden parachutes for administrators, whose responsibility seems to be denying claims to reduce cost of care while increasing revenues. Insurance

companies, especially those who enjoy the public benefit of nonprofit status, must continue making strides to tighter medical loss ratios. Administrative expenses should not rise proportionally to health care spending, and billing and coding mechanisms cannot remain overly burdensome so as to force doctors into spending more time and resources filling out forms than they do in seeing patients. Our system is complex enough. I honestly don't believe that we need to artificially and unnecessarily make it worse.

Furthermore, we know that when we can keep people healthy, the cost of providing care can be very affordable. Instead of consistently cutting funding for public health initiatives, those proven to save lives and dollars, whether in state and local health agencies, or in private insurance programs, need investment, not elimination or physical strangulation. If our goal is to keep people healthy as opposed to treating illness when it arises, what better way than to prioritize prevention and public health? Unfortunately, we've seen a retreat from these priorities in recent years, primarily because of tightening budgets, and sometimes lack of convincing evidence of any return on investment. If the payment reforms transfer a certain amount of risk to providers, then medical malpractice reform certainly has to be an appropriate part of this

legislation. The more we know about mistakes when they're made, the more we can do to prevent them from occurring again. Today's adversarial system too often fractures a patient's faith in the system, and rarely leads to justice. If we're to ask physicians to assume greater responsibilities for care, we must provide them with flexible protections. Similarly, if we're to ask patients to maintain a stake in their overall well being -- I don't know if that's a signal or if it's commentary on our health care system. We've been operating in the dark for a long time, and it's time we now shed some light on health reform through payment and provider price protection.

As I said at the outset of my remarks, we're still in the process of conducting statewide hearings on this comprehensive proposal, and have received an abundance of valuable input from a whole host of stakeholders. Thus far, some conclusions are becoming more apparent, aside from the fact that we must revise our system to restore patients to its very center, with qualified physicians taking a stake in our overall well being. This will absolutely mean that the powerful dynamics currently at play must change, and change dramatically. We must promote real primary care, which cannot be boiled down to a single doctor, but a carefully constructed team of highly skilled professionals, including nurses, our allied health fields, and

when appropriate, specialists and other ancillary components to our system. Reforming the payment methodology must also include a reexamination of the scope of practice of each type of health professional, and the creation of patient care teams that will include the patients themselves. We cannot afford the status quo in payment and pricing methodologies. We also can't simply overlay new payment and pricing methodologies on top of the current system. Payment and price reform has to be robust, and it has to be meaningful.

We also need to establish a timetable for the steps that must lead to quality improvement and cost cutting as the goals of payment and price reform. It cannot be left to inshallah, as our friends in the Middle East might say, meaning some day in the future. We must have a reasonable transition schedule for some flexibility, however, since once again, the Commonwealth will lead the nation in tackling payment and price reform, continuing to lay the foundation for yet another piece of landmark, innovative legislation. We will need to be able to make course corrections along the way of implementation as well.

Price increases based solely upon market power are no longer acceptable, and mere cost cutting or price setting without measurable quality improvements is not the answer. We as

patients deserve a better system. My constituents deserve a better system, and our professionals deserve a better system. It's my intention during this session to seek value from our health care sector and find the best methods to allocate the appropriate balance between improved quality outcome and lower cost through payment and provider price reform. The Committee on Health Care Financing looks forward to the results of these hearings this week as we draft the next chapter in Massachusetts health care reform. Thank you.

Seena Perumal Carrington

Thank you, Chairman Moore. I would now like to introduce Chairman Walsh, co-chair of the Joint Committee on Health Care Financing.

Steven M. Walsh

Thank you very much. When the lights go out, most people stop talking. I've heard Senator Moore give that speech underwater, so nothing is going to phase him. I'm a little less focused today than normal. I'm actually a consumer and a parent more

than a chairman today. As many of you know, we have (inaudible) sons, and one of them is back in the hospital, in the ICU, so I mean no disrespect when I speak and then I leave. We went in on Saturday, and we're hopeful for a speedy recovery. It always reminds me of the importance that our health care system and our institutions in this city play in our lives when we're talking about cost and we're talking about how to cut costs. We're always remembering the quality and that there is a patient at the center of that, and there is a family behind every patient.

I thought I'd shed a little bit of light, I think, on the direction that I hope the House intends to go with the partnership of our partners in the Senate, and a little bit more specifics, maybe, than we have in the past. I thank the Division, the Commissioner, and the Attorney General for offering us guidance as to the direction that we need to go, and being able to use their research and their findings to help educate our direction. We have been around the state, as most of you know. The thing that I think is most impressive this year is that the Governor, the Senate president, and the speaker all agree that something is going to happen in health care, and they all agree that it's going to happen this session. Sometimes we hear the word "urgency," and I think we all agree that something has to happen soon. But it is in the wisdom of

our leaders that they have decided that now is the time. In this session, I think we will be bolder than we've ever been before, and we will be more aggressive than we've ever been before.

As the Senate chair mentioned, we are holding hearings throughout the state, and we're hearing very different things in each area that we go. We went to Salem and we heard some of the challenges of competing with the Boston teaching hospitals when you're so close in proximity to Boston. We're in Boston, and we heard from some of the providers that struggle even today among the appearance of they're getting such high rates, yet still they are trying to keep people employed and offer the best services they can at the best price and highest quality. Then we just recently went out west, where we visited six providers west of Worcester, all the way out to Great Barrington and Lee. We learned about much different challenges. We learned, at a time where we hope to be able to mandate electronic medical records, we learned that there may be a challenge if some providers don't have service to the internet, or don't have the broadband connection that we have so long to have in the western part of our state. There are different challenges and different disparities that we face in each and every area that we go. As we keep in mind cost, and clearly, cost is the message of this week, and the focus of, I think, these hearings and the

Governor’s bill, although he always reminds us that quality -- and the secretary will remind us again that quality is at the center of that -- as we keep in mind cost, we have to remember some other fundamental challenges. There’s some things, I think, that the committee has looked at, and I’ll offer the themes today that I think the committee has kept in mind, and then we’ll finish with payment.

I think the first thing that we’ve talked about is consumer protection or patient education. As many of you know, if you go to buy a new car, you might go to three or four dealerships. You might test drive the car. You might ask for the car facts for the car. That car might cost you $20,000. Your health insurance is $20,000 a year for life, and most people have no idea what they’re buying. We need to make sure that patients are our partner in this, and that patients know exactly what is in the insurance that they purchase, and exactly what they intend to get for that. We need to ask them to be our partner, and we need to help educate the patients that they are the most important piece of this, that the leverage has to change so that they are at the center, so we don’t have a repeat of the 1990s, where patients felt as though they were being told what to do as opposed to ask what to do. I think we start with the patient

education piece, because it’s so important, that reminder that patients are at the center.

The next piece, I think, is the electronic medical records section that I mentioned before and the secretary mentioned. It is imperative that if you go to any hospital or any provider in the state today, that you are able to access your record. The fact that we can’t do that in this technological age is absolutely unacceptable. If I go to a hospital today, I should not be subjected to a whole battery of tests that all of you are going to pay for because we haven’t figured out how to access medical records in a timely and appropriate fashion. We’re hoping that by 2015, we can meet the federal requirement, but we can go one step further -- that there’s interoperability among all providers, and in addition, you as a patient own that record. You can have access to your record any time that you want. In addition to that, as the co-chair talked about, is the administrative simplification that is so important. When you go home from the doctor’s or hospital, how many different bills do you get on that one particular visit? Eight, 10, 12? Might be for a $6 co-pay, am $8 co-pay, a $12 co-pay. Shouldn’t you get one statement that lists exactly the services that were provided to you at exactly the cost that they were provided? And then you can make sure

that you're paying appropriately for those services? And won't that save costs over the long term? We've asked some of our partners in the insurance industry to help provide us with language on administrative simplification. It's our goal that we can save some 15-25% in administrative simplification.

Workforce development is a piece that Secretary Bialecki has talked about, and it's a critical, critical piece to what we do for two reasons. One, we need to make sure that we have enough primary care providers to be able to operate in this system that we hope to create. Piece two is, if we begin to alter the system in any way, we have to make sure that we don't do anything to affect the employment. Because right now, as you all are well aware, health care is our largest employer in the Commonwealth. We can make changes, we can save money, but we also should be making sure that we're training people into new jobs, into new industries, to make sure that there's no net job loss when we make major changes in the system.

Transparency and disclosure. It's inexcusable right now that you don't know the service that is being provided to you at the cost that it is. The other day at the provider price commission, we had a long, lengthy discussion about what is the cost, what is the price, and what is the payment. They are very, very

different things. It is not as simple as walking into the supermarket and seeing what a gallon of milk costs, but you should at least have the knowledge, if you walk into an office, that you know what test you're getting, at what cost you're getting it for, and what are the risks to you as a patient. That's absolutely imperative information that, right now, you can't get in the current market. It's not that anybody doesn't want to give it to you. It's that we don't have a system that allows that today. As I've always mentioned, there's no blame in this. No one's doing anything wrong. They're only operating under the system that we in government have created, so it's time to change the system and offer some different goals and some different guidance to our providers and our payers, so that our patients and our physicians become the center of this market. Medical malpractice, as the co-chair also mentioned, is a smaller piece, but it's a critical piece. Even a little bit of defensive medicine that may be going on, and the little bit of protections that we can offer to our physicians, is going to make sure that we keep our talented physicians in the Boston area, and make sure that patients can get some answers in a timely fashion. If it's necessary for there to be a settlement, there will be a settlement that they don't have to wait years and years and years for, and they can begin to do some of the healing that's so necessary.

If we come back around after looking at all those things, what do we come back to? We start with payment and we end with payment. Now, we all know, there's no one in this room who's going to suggest that fee-for-service works. There's no one who's going to suggest that it doesn't treat the sick and not treat the healthy. So why are we still stuck in a fee-for-service model? Why haven't we moved to some type of a global payment? The challenge that I have with the reports that get put out that look at global payment today is they're looking at global payments that are overlaid on a fee-for-service model. If you take a payment and you bundle it and you call it global, but it still looks at the underlying fee-for-service model, that's right -- the Attorney General is absolutely right -- that's not going to save money. But that's not the system that I think we envision in the future. We envision a system in the future where the physician and the patient can make decisions about their medical needs together. That there's a partnership in that, and when you are well, you will save money. The biggest question comes, how do we do this? As the Senator mentioned, we're still waiting for some of the things to happen that we passed in Chapter 288. What will that have on the marketplace? Do we want to wait to see whether or not some of the business cooperatives and the other things that we -- some of the pilot

programs or the commissions? I don't think we want to wait, but I think we need to make sure that nothing that we do is in conflict with the things that we did in Chapter 305 or Chapter 288. That they complement the moves that the systems already make, and they make some acknowledgements that the market has moved on its own in some direction.

But we also need to make sure that whoever is the governing body that oversees the next chapter of health care has the expertise and the capacity to be able to do the things that we ask them to do, or we're right back where we started, with a system that continues to be broken, that continues to reward us for being sick as opposed to reward us for being healthy. Even health insurance -- I'm sorry, even auto insurance has figured this out. If you're a good driver, you save a little money. Why can't we figure this out in health care? Why is there absolutely nothing positive -- other than living longer, and I get that's a huge incentive -- but when you do the right thing, there is no motivation to do the right thing in the current system. There is no motivation to be healthy. There is no motivation to enter a wellness program. There is no motivation to take care of you and your family with preventive medicine, because right now, you're only rewarded, providers are only rewarded, payers are only rewarded, when you go to the doctor's. That isn't good for

you, it’s not good for your family, and it sure as heck isn’t good for the system.

We will have a good bill this year. We applaud the administration for starting this dialogue and for putting together such a great piece. We acknowledge the great work of the commission and the Attorney General of making sure that they are able to inform some of the decisions that we need to make. But we need to go further. Everyone in this room can be our partner in this. We’ve said many times before -- the Senator and I have said -- we want you to come before us. We want you to be our partner. We want you to offer us ideas, creativity, innovation, and language. But what we don’t want you to do is suggest that the system works and that nothing should change. It’s going to change one way or another. It would be much better if we can all be partners in that and make sure that we’re rewarding our families, our friends, our loved ones, when they’re healthy. Thank you very much, and again, I apologize for having to leave, and I wish you great luck in the hearings this week.

Seena Perumal Carrington

Thank you, Chairman. I would now like to introduce Chairman Sanchez, Chair of the Joint Committee on Public Health.

Jeffrey Sanchez

Good morning, everyone. Commissioner Carrington and members of the panel, I am Jeffrey Sanchez. I'm the State Representative from the 15th Suffolk district, and I'm also the House Chairman of the Joint Committee on Public Health. I want to thank you for inviting me to today's proceedings. I want to particularly express my appreciation for the work that the Division, the Attorney General, in providing the recent reports on trends in premium levels, price variation, health care expenditures, and cost drivers. I'd also like to applaud Chairman Moore and my colleague, Chairman Walsh, for getting out there early on, for engaging as hard as you have in these past few weeks. The hearings are long, but I hear that you guys are doing a great job listening and making everybody feel like they're a part of this discussion, as well as my constituent, Secretary JudyAnn Bigby, and also the Secretary of A&F, Jay Gonzalez. Thank you so

much for your support and all the hard work you've put into the bill.

Over the next several days, the ugly truths of our fractured health care delivery system are going to be laid bare. As we have during similar investigations over the past years, we're going to hear the dire prognosis of health care as we know it, and that it's in this critical condition. Health care spending, we know, is crippling the economy, and the way care is provided fails to address the needs of the families, businesses, and most health care providers. Private sector health care costs are preventing our businesses from hiring employees and forcing employers to reduce health benefits and shift more costs onto their workers. Not only that, this public sector spending on health care is (inaudible) other funding for other critical services, such as education, public safety, and local aid, while also threatening to erode the gains in access to coverage achieved through Chapter 58.

There's one graph that I enjoy bringing out to groups throughout my district, and even throughout the Commonwealth. It's that Mass taxpayer foundation pie chart that shows how much our health care costs were in 2000 as opposed to how much we're spending now. In 2000, we were spending about 20% of our costs.

Now, we're up to, what, 34, 35%? It's just unsustainable. We know that health care is delivered through a dysfunctional market, characterized by misaligned provider incentives that reward volume over value; regulatory and cultural barriers to coordinated patient care and preventative health care; prices for services and provider payments that vary greatly without regard to differences in quality of care; complexity of services or the type of patient; and a lack of transparency in pricing contracting and payment practices that prevent anyone involved from comparing the quality of value of health care services and making informed decisions on how, where, and from whom they should seek care.

We've heard the analogy of our system being a sick care system as opposed to a wellness system. We shortchange the critical support systems that are related to community health and wellness. Despite our best efforts to find creative solutions to reduce the cost of care within the boundaries of our current health system, families and businesses and payers and public payers have finally acknowledged that the only way to get ourselves out of the hole that we're in is to tackle the fundamental flaws that have led us to this point. We can't fool ourselves that doing nothing is an option any longer. We have to change our system to a system that focuses on primary care

and promotes patient-centered care coordination to reduce fragmentation, improve outcomes, and reduce costs. We must promote innovations in patient care to eliminate racial and ethnic disparities in access to care, and provide patients the right to care, at the right place, at the right time. We must make sure that we bridge the divide between public health and clinical health by committing to making both sustained investments in prevention of wellness to complement and support treatment and care. Just recently, we know that our Department of Public Health was affected by federal cuts. Again, it seems that prevention of wellness is always that easy thing that we can always cut out. It shouldn't be that way. As we look to changing payment systems, as we look to changing the structural impediments along the way, we have to figure out, how do we build community-based health principles within any payment systems that we do put together?

From the perspective of the [Chair] of Public Health, the failure begins with a lack of emphasis on our preventative health policies. We focused on the financial side of getting care to the sick, to the exclusion of where we should exert our efforts to prevent sickness and disease in the first place. Less than 5% of all health expenditures are spent on prevention of wellness efforts. Asthma, heart disease, diabetes, and other

chronic illnesses are preventable and treatable, but tragically, the incident rates for these and other chronic conditions are on the rise across all demographics. Our health policies have to be aimed at curbing the effect that these conditions have on our health and our bottom line, and there are many factors that contribute to health and well being that fall outside of the health care setting. Social, economic, and environmental factors can be mitigated by strategic public health initiatives that utilize community-based interventions to achieve positive solutions for entire population groups.

I use an example all the time about looking at my community and other communities. When you drive into Jamaica Plain, to the Roxbury side, and let’s say you drive in some other communities, you might smell the baking of fresh bran muffins, walking along the main street business district. Well, in mine, that’s not necessarily the case. The corner of Centre Street and Chestnut Street in Jamaica Plain -- these coffee shops start frying pork at 7 o’clock in the morning. Why? Because it’s culturally relevant. In our Latin culture, eating pork, rice, meats, starches, heavy starches -- it’s a part of our diet, and it’s hard to break out of that. We need to make sure that, whatever we do, that we figure out a way, how do we change the dynamic? There are certain innovations, there are certain instances,

examples, that are out there, at a very small scale, that are trying to make the change, to get people out, to tell them the value of exercise, explain to them the value of changing diet. But it’s a challenge. That’s why we have to make sure that any preventative health policies and efforts that we have should educate citizens on the importance of making healthy choices, but it has to be an integral part of any of the health care savings initiatives that we do put together.

Within the health care setting, the policies of prevention can be best served by continuing to move forward with concepts like patient-centered medical homes, primary care models, and by scaling up successful chronic disease management models for specific populations that have proven to be effective in controlling costs and improving health outcomes. In this recent session, I filed a couple of bills relative to looking at ideas that are already out there. An idea that Dr. Tim Ferris, and his successful model over at Mass General Hospital that provides enhanced care through utilization of nurse care managers, integrated into physician-based primary practice. Not only that, but we have a silent storm, I’ll say, in the work of Dr. Robert Master and the Commonwealth Care Alliance, with a design to delivery model that provides a spectrum of medical and social services for dual eligible beneficiaries, who are also

physically and mentally disabled. We already have demonstrated that these coordinated care models do work. They're effective in realizing cost savings and have incredible quality outcomes, and their success is directly linked to the increased utilization of non-physician clinicians -- in particular, advanced practice nurses and physician assistants. The expanded utilization of non-physician clinicians improves efficiency of care, reduces costs, frees up physicians and advanced clinicians to concentrate their efforts on providing care to more complex patients, all without sacrificing patient safety or weakening the quality of care.

Regulatory and institutional obstacles to team-based care, including outdated or conflicting scope of practice regulations, should be removed. The patient-centered medical home and care coordination models also demonstrate the need to ensure smooth integration of health information technology, especially the electronic health care records, which I'm so happy that Chairman Walsh and Chairman Moore have mentioned today. In proof, care coordination, care transitions, performance management, reporting, patient and purchaser empowerment, and contracting and risk management. As the dialogue about payment reform in Massachusetts moves towards basing payment on value, not volume, the issues of patient safety and quality become even more

important. In the committee, we've also focused on medical errors and hospital-acquired infections, which waste hundreds of millions of dollars in Massachusetts each year, unnecessary costs that can be avoided through the implementation of systematic and cultural improvements, such as checklists, screenings, and other methods. When errors do occur, sensible malpractice reforms can also reduce avoidable health care costs. An example is the University of Michigan's health systems, providing and encouraging physicians' early disclosure to apology for mistakes and errors, or expanded peer review here, to identify potential improvements to correct system failures. There are other actions that must be included in the discussion of cost control and reform, and that is, also, we need to improve our general administrative and oversight capacity to identify the structural inefficiencies in the delivery of health care to root out wasteful spending and fraud.

We must provide for standardized transparent data sets on clinical outcomes, quality measures, provider payments, and other information necessary to encourage the creation of value-based insurance, design, and formed by comparative effectiveness research. In the last session, we were able to pass the All Payer Claims Database legislation, which is helping us be actually able to see who's being paid, how they're being paid,

and what they're being paid for. I understand that it is a monumental task, given the amount of information that we do receive, and making sure that we're able to put out reports and information that's easy for us to understand as consumers as well as policymakers and so on. We must carefully monitor both the consolidation of health care providers into accountable care organizations and the impact of payment reforms, the safety net providers, community health centers, and other critical health resources, to ensure that moving forward, our efforts to reduce ethnic, racial, and geographic disparities in access to care, and adequately protect the interests of the health care consumer.

I know that I shared this view with my legislative colleagues on the road ahead of us, and that the road ahead of us will not be easy. To achieve a lasting and comprehensive solution to the problems plaguing our system, our health care delivery system, I'd suggest to the panel and to those who appear before it that we must return to the principle when we embark on health care reform, the principle of shared responsibility that led us to successfully pass new universal coverage just five short years ago. Much like expanding access to coverage, payment and delivery reform is a daunting challenge that will require all of us to make difficult choices, and, yes, sacrifice certain

aspects of our way of doing things that each stakeholder may find hard to accept. But those sacrifices can and will be offset by the shared gains we will all enjoy when we succeed in bringing rational change to this dysfunctional market. I look forward to working with the members of the panel and forging ahead with the next steps, as well as my legislative colleagues and everyone in our community. You are the large number of people -- I know that there’s a large number of people that are here waiting to testify, and I just want to thank you all for your attention this morning.

Seena Perumal Carrington

Thank you, Chairman Sanchez. I know we all feel honored to live in a commonwealth that has a legislature with such deep commitment and leadership in tackling health care costs, so thank you all again. Now I have the pleasure of introducing Dr. JudyAnn Bigby, Secretary of the Executive Office of Health and Human Services.

JudyAnn Bigby

Good morning. It still is morning, right? I'm very happy to be here. I think that we all know why we are here, why we're all proud of the near-universal coverage that we've achieved in Massachusetts, and the positive impact. I emphasize that, because what is the point of saying nearly everyone is covered if we can't indicate what the outcomes are. We've seen what some of the outcomes are. More people describe having a regular provider. We know that more people are getting preventive checkups. We have many things to be proud of, but we know that in order to sustain the success, we have to find a way to make sure that we continue to improve access to care, and improve the quality of care and bring down health care cost. These hearings will give us an opportunity to better understand health care costs in Massachusetts, but more importantly, we're here to explore solutions. We know there's no silver bullet to controlling cost, and that is why it's so important to hear from multiple perspectives. I want to thank the team at the Division of Health Care Finance and Policy. They've done tremendous work putting out the report and organizing these hearings so that they will be guaranteed to be fruitful. I also want to thank the Attorney General's office for their partnership in this effort. As Commissioner Carrington just indicated, I want to thank

Senator Moore, Representative Walsh, and Representative Sanchez. As you can hear from their testimonies, we are very fortunate in Massachusetts to have an informed legislature, and one that is willing to take risks and say the impossible can be done in Massachusetts, so thank you.

There are a few things that the reports that have been posted over the last month or so tell us. There are a few things that I'd like to highlight, however. Just in case people don't know, we spend nearly $37 billion annually on health care in Massachusetts. Given that number, it's no surprise that it's the number one player in Massachusetts. Between 2007 and 2008, spending overall increased by nearly 5%. That growth was highest in the private market, at about 6%, while Medicare and Medicaid grew less aggressively, with Mass Health, no surprise to the providers, growing at only 2.8%. What is important to understand about these growths, however, is that in the private market, spending increased largely due to increasing prices, not utilization, but both Medicare and Mass Health spending increases were triggered into increased utilization. We do know that over the last few years, we've added more than 260,000 new people to the [rolls] in Mass Health.

Private insurance premiums continue to go up, with small businesses seeing a faster growth of increases and paying more for their premiums. But as we're paying more for premiums, what we are seeing is that the level of benefits by private group health insurance has declined, and member cost sharing has increased. Prices paid for the same hospital inpatient services for physician and professional services vary significantly across the Commonwealth. For the measures that we've looked at in terms of the available quality metrics, we cannot identify a true difference in quality. However, this is not surprising, given that most carriers do not pay for these quality measures. In fact, if you look at these quality measures, we should be requiring that every provider meet the standard of these measures, because they indicate the minimum standard of care that providers should be able to achieve for those particular outcomes and procedures. I would hate to be in a state that said it's OK to pay a provider less because they're not meeting these quality measures, as opposed to saying, why aren't you meeting them, and you must meet them.

For all of the reports that the Division has put out, it will be no surprise to anyone that Medicaid rates are consistently lower than the rates paid by private payers. Medicare rates are also lower. While most would say that we underpay, there is the

notion that perhaps some of the private insurers overpay, and it is the day when we can come to agreement about what the price should be that we can get, I think, to the consensus about how much under and overpayment there would be in the market.

These findings were not surprising. They support the need to think comprehensively about how to decrease cost and how to do it now. However, we must address more than the cost issue if we want to maintain access to care, improve the quality of care, and bring down cost. It's increasingly clear that the quality of care -- I'm sorry, that we need to transform the health care delivery system. So rather than focusing on the price of an admission or a test or procedure, and how many of these we are paying for, we need to focus on processes of care and clinical practice improvement, and improving quality. Now we have a combination of too little care delivered in some places, and we see disparities, or too little care delivered in the right place, such as primary care instead of the emergency department. We know that some are receiving too much care, or the wrong care, and not only does this drive up cost, but it is also harmful. All this goes on as the cost of care to consumers, employers, and to government keeps going up. The answer to this conundrum is a value-based system that is focused on ensuring that individuals are getting the best value out of their health

care dollars. A system based on value for the patients will align incentives to achieve the outcomes we want, access and quality at lower and sustainable cost. Value in health care is not determined by the price of one unit of care, and a quality measure that approximates whether an outcome for that unit of care is acceptable. Rather, it should be determined by the patient's outcome of care over the full cycle of care. In order to realize this value, we need integrated systems, and we must pay for those things that focus on integration.

We have begun to recognize this concept in the Mass Health program, with the patient-centered medical home initiative. The state, in partnership with commercial payers, is paying primary care providers to provide integrated preventive and primary care, chronic care management, and care coordination. Practices across the state are participating with the goal of improving outcomes for common conditions, such as diabetes, asthma, and attention deficit disorder, and to prevent unnecessary emergency department visits and hospitalizations. This model has been shown to both improve the quality of care and reduce cost and demonstrations around the country. And, I would argue, the model that we use, where we agree to pay primary care providers more, allows them the flexibility to understand what they need to do in their practices to achieve these improved outcomes.

Their care coordination could be done by a community health worker, which, right now, for the most part, no insurer pays for. But this model that we've implemented allows them the flexibility to use their payments to ensure this type of outreach to populations that might be difficult to meet. This flexibility ensures that we're not promoting a one-size-fits-all approach.

Mass Health has also initiated an effort to provide integrated care for individuals with serious behavioral health and medical problems, as demonstrated in our still-active procurement for more than 300,000 Mass Health members. We know that these members account for 5% of our population, but account for 50% of our costs. The responders will need to propose how to ensure that care for these individuals is integrated, and that behavioral health services are carved in, as opposed to being carved out, which is the model that is almost universally used right now. After decades of carving out behavioral health, we know that it doesn't work. In partnership with the federal Centers for Medicare and Medicaid Services, we proposed a similar strategy for ensuring integrated care for individuals who are duly eligible for Medicare and Medicaid. We estimate that this will save about 2% of the $4 billion we spend on this population. Recently, we also released a request for information

to provide Mass Health guidance about how to define integrated care organizations, or ACOs, as they're commonly referred to, and to solicit recommendations for how the state can support the diverse array of providers to become ACOs.

All of these initiatives are designed to create more integrated delivery systems. Our goal is to build a strong primary care foundation that recognizes the needs of different populations, move to value-based payments to encourage an integrated delivery system, and improve outcomes for patients. However, the executive office cannot do this alone. Governor Patrick filed legislation in February that will move the system toward one that is more value-based instead of volume-based. The Governor's bill accomplishes this by promoting a careful and deliberate path to changing the way health care is paid for and delivered. This is not a radical change. Many payers and providers are already moving away from fee-for-service payments, and forming more integrated care organizations. But as we know from research that will be presented here in closer detail, we need a critical mass of providers doing this, and we need better systems of integration in order to see the impact.

It is because this transition requires thoughtful planning, and should not take place in a haphazard manner, that the Governor's

bill is so necessary. The Governor's bill guides this transformation in five important ways. First, the bill gives us the tools we need to reduce some health care costs right now. Transitioning to value-based payments and integrated accountable health care delivery systems will reduce the cost of care over time, and the bill promotes this transformation. But it also directs the Division of Insurance to consider provider rates and whether they are below or above a medium level when examining premium rate increases. This authority, along with the existing authority DOI has over insurance carrier premiums, will have an immediate impact on health care costs by giving us the tools we need to ensure that health insurance premiums do not continue to increase simply because some providers receive extraordinary rates. The Governor's bill therefore addresses the disparities that exist among providers today, and ensures that as the system transitions, we do no simply bake in the current inequalities.

Second, the bill sets goals and deadlines. It is vital that we make this transition together, and we do it deliberately and thoughtfully. Setting a goal that is public ensures that we will do it. The bill sets a public goal of developing sufficient numbers of integrated care organizations to make it possible to have an alternative to fee-for-service be the predominant method of payment by 2015. It also directs state purchasers of health

care, Mass Health, the Connector, and GIC to be using these principles by 2014. By setting goals and holding ourselves to a timetable, we encourage action and innovation. Once we have collectively announced that we're going to do something -- not do it sometime in the future, not do it sometime as time permits, but to do it now -- we will unleash a thousand brilliant minds to innovate and create and find better ways to provide care and pay for that care.

Third, the bill provides a process for establishing definitions of alternative payment methodologies and minimum standards, under which providers may organize into ACOs, or claim that they're ACOs, and would like to receive these alternative payments. Included in this minimum standard is primary care as a foundation for integration, and the need to include behavioral health in the range of services delivered or accounted for in the payments. The bill also calls for standardized data reporting quality measurement risk adjustment and other procedures to ensure a more simplified system as we move forward.

Fourth, the bill notes that the importance of ensuring that any financial risk taken on by providers is appropriately regulated and that there are procedures in place to ensure that providers

don’t become insolvent due to clinical conditions of their patients and their associated cost when they are beyond the control of providers, and that patients are protected.

Lastly, the bill establishes a statewide health resource planning authority at the Department of Public Health to promote an organized approach to further developing health care resources in Massachusetts. This includes the vision for what our workforce should look like in the future. The bill includes numerous other provisions, including an intervention to address physician liability, oversight of consolidation by the Attorney General. These are necessary for the success of this transformation. I know that over the next few days, we will hear diverse opinions about the strength of some of these initiatives to control cost and improve care. I’m excited about what we will learn, and look forward to ensuring that as we continue to develop programs and work with the legislature to produce a bill the Governor can sign this fall, hopefully, we will take advantage of the wealth of information presented in these hearings over the next few days. Thank you very much.

Seena Perumal Carrington

Thank you, Secretary. I would now like to introduce Secretary Jay Gonzalez from the Executive Office for Administration and Finance.

Jay Gonzalez

Good morning, everybody. I want to thank the Division for holding these hearings on this critical topic. I wanted to focus, as the budget guy, focus on the impacts of all of this on state and municipal budgets. I just want to start with context. We are facing a new fiscal reality in government. We went, for years, in state government, relying on volatile tax revenues, capital gains tax revenues, to support budgetary spending, which basically resulted in a structural deficit, which, I'm glad to say, going into next year, based on the Governor's budget and the budgets in the House and Senate, is eliminated. The elimination of that takes a lot of tough decisions and forced us to squeeze the budget in some ways which presents challenges. We also have a new fiscal reality because of where tax revenues are. The great recession has permanently shifted downwards our sustainable level of tax revenues. Just to put it in

perspective, next year's tax revenue estimate that the budget is based on is still less than five fiscal years earlier, in fiscal '08. Less than what our actual tax revenues were five years ago, and that's after taking into account about a billion dollars of tax revenues resulting from the sales tax increase a few years ago. Completely different world. These factors are constraining our ability to continue to purchase health insurance through our subsidized programs and for state employees. But our biggest challenge is health care costs themselves, which is why this hearing is so important.

I just want to give you some perspective on the extent of the challenge for government of the cost of health care. Representative Sanchez referred to the fact that health care costs are eating up a bigger and bigger share of the state budget. In 1998, fiscal '98, it was about 21% of all state spending. Next year, it will be about 40% of all state spending. Based on our analysis, if things just continue to go the way they have been going, by 2020, just eight years beyond next year, it will be 50% of the state budget. It is crowding out everything else state government needs to do. It's reducing the share of the total state budget that we give to cities and towns to support all the critical local services they provide, environmental regulation. Everything else state government does

is being squeezed. We're on a path that if we continue, we will end up being -- government will end up doing nothing more than providing health insurance, which obviously is not an acceptable result. It's the same story at the local level. Over the last few years, based on some analysis the Mass Taxpayers Foundation has done, just about all of the property tax increases that they're allowed under Proposition 2.5 have gone to pay for increases in health care costs. From 2000 to 2007, the growth in health care costs at the municipal level has exceeded the growth in Chapter 70 assistance the state has given to local school districts by $300 million. Even just comparing municipal health care costs to state health care costs, where we have a significant challenge in the growth in state health care costs -- at the municipal level, from 2001 to 2010, their health care cost increases have exceeded ours by $3 billion. So this is a huge issue for government, and it's a huge challenge that is daunting, but I would say not insurmountable.

We are working very hard to address these challenges, because we have to. Here are some of the ways we're doing that. Systemic reform. This is the issue that Secretary Bigby and the other speakers have talked about, it's the issue the Governor's legislation addresses, to fundamentally change the way we pay for and deliver health care in Massachusetts. We need that

reform in order to make health care costs sustainable, not only for government, but for businesses and individuals and families going forward. The Governor himself will be here later today to talk more about his legislation and that reform, and why it's absolutely critical for long-term sustainability. We at the state also need to take advantage of the large volume of health insurance we purchase through our subsidized programs and state employee program to drive that systemic reform and innovative changes to control cost and improve quality in the market. We have been moving that direction. The secretary mentioned a number of the initiatives we've undertaken, and we intend, as the Governor's legislation calls for, to get there completely by 2014. But we cannot wait, based on this new fiscal reality, for the systemic reform in order to control health care cost in government. We are taking a number of steps and a number of initiatives right now to control our health care costs so we can preserve not only the level of benefits we provide for the people in those programs, but also everything else we do in state government, to the greatest extent possible.

Some examples of what we're doing. The Health Care Connector, which provides subsidized health insurance under health care reform for a portion of our population not eligible for Mass Health under the Commonwealth Care program, has implemented an

innovative procurement strategy to try to incentivize limited networks and other cost reductions by the health insurance plans that provide coverage for that population, and that strategy has worked, saving at least $80 million in costs next fiscal year. The Group Insurance Commission, which provides health insurance for state employees, through some contracting approaches, and an active reenrollment, for the first time, requiring every state employee to reenroll, and through incentives we provide to state employees to enroll in limited network plans that reduce costs for them and for us, has proven to be successful. Ninety-nine percent of state employees reenrolled. We now have about 30% of state employees enrolled in limited network plans, which is going to save the state $30 million next fiscal year. A great result.

Secretary Bigby mentioned steps we're taking in the Mass Health program through the innovative procurement there to move in an aggressive way to a coordinated care model, particularly for those enrollees who are our most expensive, highest-utilizing members. On the municipal front, we are on the verge of enacting municipal health insurance reform, which will give municipal managers the tools to drive down health insurance costs, and save tens of millions of dollars now to be used to preserve critical local services, while at the same time ensuring that

municipal employees who depend on those insurance plans have a meaningful voice in how to get to that result. So a lot of very exciting cost-control steps that are going to make an enormous difference as we go into next fiscal year.

I just want to end by making clear, in case I haven't already, health care costs, and the growth trend in health care costs, threaten the very viability of government. Everything government does is threatened if we do not address this challenge. We have to. It's not an option. I'm glad to say we are doing it, and we've had some success already. We're doing things differently, because we have to do things differently, and I'm optimistic, based on the results we've seen and the commitment, not only of the Governor and the administration, but the legislature and all the other stakeholders who are here today, to fundamentally change the way we pay for and deliver health care services in Massachusetts to bring down costs and improve quality; that we will get to that point where our health care costs are sustainable, and government remains viable. Thank you very much.

Seena Perumal Carrington

Thank you, Secretary. The Governor has clearly articulated that containing health care costs is one of his key priorities, if not his number one priority, and both Secretary Bigby and Secretary Gonzalez articulated some of the ways in which government and the administration is trying to address this intensifying challenge. Last but not least, I would like to introduce Inspector General Greg Sullivan to provide a few remarks. Thank you.

Gregory W. Sullivan

Good morning. Thank you for giving me the opportunity to offer some thoughts from the perspective of the Inspector General's office. I'd like to use this opportunity to make two central points. First, I want to advocate strongly for passage of the essential elements of Governor Patrick's health reform legislation, and specifically for expeditious passage of the proposal to enhance and expand the regulatory oversight authority of the Division of Insurance and the Department of the Attorney General over health care insurers and providers. Secondly, I want to reiterate my office's longstanding position,

that attempting to transform our health care delivery system to an all-ACO system without first putting in place such effective regulatory oversight will likely exacerbate our health care crisis -- our health cost crisis.

Most of the efforts to contain private health insurance costs in Massachusetts have focused on creating accountable care organizations and reimbursing providers through a global payment methodology. In October of 2009, I testified before the legislature’s Joint Committee on Health Care Financing, and recommended that a global payment ACO structure include review and approval of capitated global payment rates by the government in order to contain costs. In March of this year, my office issued a report that examined the Blue Cross Blue Shield global payment contract, known as the alternative quality contract, AQC. It estimated that increases in reimbursements to providers over the five-year term of an AQC contract would be in the 50% range.

I want to talk about that for a minute. I made public comments to the effect that I believe that many people have been mesmerized by this so-called AQC methodology of global payment methodology, because it would reduce the rate of increase from 11-12% at the beginning of the contract to about half of that at

the end of the contract. By virtue of this, it is called reducing the cost of health care. However, if you take those rates of increase, compound it over the five-year period, they add up to a guaranteed 50% increase in rates over five years. When the health reform act passed, Chapter 58, the average family health insurance plan in Massachusetts cost approximately $11,000. Today, the average family health insurance plan costs approximately $17,000, an increase of more than 50%. If you add to that level another increase of 50% above that base, five years from now, the average family health insurance plan in Massachusetts will cost $25,000. That is a shocking number to think about. It would mean that a person working 40 hours a week would be paying about $12 an hour out of his pocket, just for health insurance. My concern all along has been this: the global payment structure by itself does not inherently contain costs. The proven economic advantages of global payment structure can be offset and overshadowed by global payment contracts that reflect excessive concentration of market power, disproportionate pricing structures, and lack of competitive fairness.

Later today, Attorney General Martha Coakley will be discussing her recent report. I think that it’s one of the most important reports in the last 20 years in Massachusetts, and one that we

should all study very carefully. We have, at the Inspector General's office, and we feel that we can strongly say that the conclusions that she has reached, and her staff and Tom O'Brien and her team have put together, are profoundly important and should become a central way of viewing any legislation. What can be done to address the problems identified in that report? The Governor has asked the legislature for important tools that I believe are necessary to address the crisis in the private market. Specifically, he asked that the powers of the Division of Insurance be broadened to allow the Commissioner of Insurance to set maximum increases in provider reimbursement rates, and to allow those maximum increases to vary by categories of contracts or providers. He's also proposed an expansion of the authority of the Attorney General, to protect the interests of the consumers and guard against unfair competition.

I am perhaps one of the most ardent supporters of this legislation, and I'm spending most of my time trying to advocate for its passage. We are in a dire crisis, and we have very little time to act. I have raised the concern about rates in a letter to Governor Patrick recently, with the concern that major insurers and providers are negotiating today long-term contracts early to get ahead of the legislation. Governor Patrick responded to me and said, any entity that thinks it can beat the

clock by locking in cost increases now to pass along to consumers later is mistaken. The Division of Insurance plays a critical role in Massachusetts regulation. In the recent past, our automobile insurance rates have declined. We've done this by a combination of careful, diligent, prudent review, combined with more open market practices. This has been a successful formula, and I think that it can be utilized and applied in the health care field. I strongly support the Governor's proposals and ask the legislature to enact them. If the legislature needs additional time to reflect on the many other aspects of the bill, including system redesign and conversion to an all-ACO system in Massachusetts, that would be more than reasonable to take that time.

I want to stress today what I consider to be an option that they should, in my opinion, utilize. That is to break out of the bill the sections that pertain to the increased regulatory authority of the Division of Insurance and the Department of the Attorney General. I would guess that had this expanded authority of the Division of Insurance been passed two years ago, the premium health insurance rates in Massachusetts would be substantially less today than they are. It's going to take time for the Division of Insurance to ramp up and become competent to fulfill this function, as the Attorney General's office has already

demonstrated, in this report and in prior reports, the competency of the Attorney General's office. These are two entities in which we can have great competence. Many people don't think about the Department of the Attorney General as being involved in economics and the health care industry, but they are involved in the economics and the insurance industry, and they've done an excellent job. I think the work that you will hear this afternoon will show the level of competency that they have been able to demonstrate. I strongly support Governor Patrick's bill, and I urge the legislature to take action as soon as possible to empower those two important agencies, the Division of Insurance and the Department of the Attorney General, to take action as soon as possible to try to bring these costs under control. Thank you for the opportunity to testify today. I appreciate it very much.

Seena Perumal Carrington

Thank you, Inspector General. We will now actually turn to two of the expert consultants who assisted the Division in their analysis of healthcare expenditures and premium trends. We're fortunate to have Dianna Welch and Deborah Chollet here with us today. I believe Dianna's going first. As I had mentioned at the

beginning, if you do have any questions for the presenters, there are index cards in your folders. Please write your questions down there, and then there will be members of my team walking around who will collect those, and we'll ask some of those questions today. Thank you.

Dianna K. Welch

Thank you. Good morning. I'm going to spend a few minutes walking through the premium trend analysis that we performed for the Division. Our analysis focused on the years from 2007 to 2009. That was the year where we primarily had the most detailed data from the carriers. The source of our data was detailed data from the commercial health carriers in Massachusetts. Our analysis covered enrollee demographics in Massachusetts, trends in the premiums paid by employers and consumers for health insurance, medical expenses and retention included in those premiums. We also supplemented the results, where we could, with published financial statement data from 2010 and some data from the carriers.

What we found was that adjusted premiums increased by about 5-10% over the study period. By adjusted premiums, I mean that

these have been adjusted to back out the impact of employers and consumers buying down their benefits to try to mitigate their premium increases. These premium trends, compared to general inflation trends [of] roughly 2%. One thing I'll point out on the slide -- if you look in the table on the top, which is the unadjusted premium trends, or what the consumers actually saw their premiums increase after changes in their benefits, the small groups from 2008 to 2009 had premium increases of 2.2%. This is compared to the adjusted premiums, which back out those benefit buy downs of 9.5%. This is a very large benefit buy down that we saw in the small group market in 2009, much bigger than we saw in the other markets, or in the previous year.

To show a little bit more about the benefit buy down in the small group market, this shows the percentage of members that were in a given actuarial value range, where actuarial value is a measure of the richness of a benefit plan. You can see the sort of royal blue color line are the members that had actuarial values of less than .7, so this was the lowest level of coverage that we saw in the analysis. You can see how that blue line starts very low in the beginning of 2007, on the left side of the graph, and by the end of 2009, it becomes about 50% of the members in the small group market. So significant buy downs in the market over these two years. The buy down was about 3.6%

from 2007 to 2008, and 6.6% from 2008 to 2009, meaning that more and more of the members in the small group market are now approaching that minimum credible coverage level of benefits.

Small group premiums, when adjusted to consistent demographics and benefit levels as the midsize and large group markets, the premium levels were higher for small groups in the three years that we studied. It's also important to note that these numbers here are averages across the entire market. What we'll see in a couple of slides is that there is a very significant variation from group to group in the small group market. The higher small group premiums were driven predominantly by higher claims expenses. These are these adjusted premiums, so again, on consistent demographics and benefits, small groups had both higher claims as well as higher retention, which is the portion of the premium that carriers maintain to pay for their administrative expenses, as well as a contribution to surplus or profit. What we saw was, in 2007 and 2008, the small groups paid about 120% of what a large group would pay toward that retention component of the premium, while in 2009, that amount rose to 141%. Just one thing I will point out, that's based on the actual results that were experienced by the carriers, and not necessarily what they were pricing to, but what actually emerged after all of the claims were paid.

Again, the previous slide is focused on the averages. This slide is showing more of the variation in the premium rate increases. This is showing groups that renewed in calendar year 2009, and the quoted rate increases that they received, meaning that when their renewal came up, they were sent a renewal notice by the carrier, quoted a rate, assuming essentially no change in the benefits that they would pay. These amounts do include any kind of changes in demographics that may have occurred in the group since the prior renewal.

The lines on the chart here, the ones with the circles on the lines, those are the mid-sized groups, so groups that have 51-499 employees, while the lines that do not have the circles on them, those are the small group market. So kind of right in the center of the graph, roughly 25% of group members in all of these group sizes had renewal rate increases quoted in the range of about 10-15%. What you can see is, if you look to the left of that, those groups that were more likely to have a lower increase than the 5-10% amount were the mid-sized groups, whereas the smaller groups were much more likely to be on the right side of that chart, receiving quoted rate increases that could have been in excess of 35%.

Medical loss ratios also increased in 2009. From 2007 to 2009, they increased from 88% to 91%, with loss ratios being greatest in the individual and small group markets. The result of this financial experience in 2009 was financial losses for the carriers overall, across all commercial business, as opposed to what they priced for in the premiums, was to have roughly 25% of that retention component of the premium intended to be for surplus for not-for-profit companies or for for-profit companies. Now, we do have some preliminary data from 2010, which shows a decrease in the medical loss ratio, decreasing from 90.5% in 2009 to 89.4% in 2010. This, after several years of increasing loss ratios. This brought the market back to a breakeven point. Rather than having financial losses in total across the commercial market, there was a breakeven, so no profit or loss for the carriers in aggregate. The decrease in the loss ratios from 2009 to 2010 appear to be largely based on a slowing trend in medical expenditures, both locally and nationally. You can see here, in 2008 and 2009, the claims expenditures increased per member, per month by about 6.3%, while, in 2010, expenditures increased by only 3.7%. These expenditures are after any kind of changes in cost sharing, so they would reflect if the members are paying higher amounts of co-pays or deductibles or cost sharing. However, we have seen, nationally, and also in the written testimony from the carriers,

the trends were, in fact, lower in 2010, aside from reductions in benefits.

Now to the premium in 2010. This is a similar chart to one that we looked at a few slides ago, although this is showing the quoted rate increases for the first quarter of 2010. First quarter 2010 was the last quarter for which detailed data was available at the time that we were requesting the data for this analysis, and it also precedes the increased authority of the Division of Insurance to review rate increases. What you can see here is the lines with the dots on them, those midsize employer rate increases, would look very quite similar to the previous chart that we saw for 2009. On the other hand, the small group rate increases sort of grading down, with fewer and fewer members at those higher rate increases. We saw that quite a few members, 10% or more of the small group members, are still in those areas of rate increase that are quite high, including those that are greater than 35%, clearly showing that into the beginning of 2010, the premiums did continue to outpace inflation by a significant margin. With that, I will turn it over to Deborah.

Deborah Chollet

Good morning. I'm going to talk this morning about the health care cost component that Dianna Welch mentioned underlay much of the increase in premiums, especially in 2009. The information that I'm presenting is drawn from an analysis of health insurance claims, both private insurance claims, Medicare claims, and Mass Health claims. We were able to look at private insurance claims in three years, 2007, 8, and 9, and therefore we have two years of growth to observe in the private pay area. For Medicare and for Mass Health, those data were available in time for this study only for 2007 and 2008. So much of the discussion around growth will compare private pay to Medicare and Mass Health in the 2007, 2008 change, and then we'll look at what happened to private pay in 2009.

These three payers are not the only payers for health care services. There certainly are many other kinds of health care services, especially for health care professionals that are not covered by insurance plans that garner payment and that the federal national health insurance expenditure accounts. For example, with considered health care spending. We're looking only at insurance spending and spending in comprehensive coverage for health care services. We're looking at the three

big payers: private insurance, Medicare, and Mass Health. Looking only at these three payers, the single largest sector is private insurance, and therefore what private insurance does certainly drives a lot of total health care spending among those three payers, but Medicare and Mass Health are obviously also very important. They are not coordinated with one another, but the public payers overall represent more than half of health care spending in Massachusetts, in insured, comprehensive arrangements.

The growth in health care spending, and this includes, by the way, not only the payments made by these large third-party payers, but also the cost sharing that patients pay when they use health care services. These payments grew very rapidly over a period of time in which Massachusetts's economy was, like the nation, in recession. We observed fast growth, almost 6%, in private insurance payments, per member year, and almost 5% for Medicare as well. Mass Health expenditures grew more slowly than either of the other two, but even Mass Health expenditures grew faster than the Massachusetts economy. We see a dramatic increase in private pay spending from 2007 to 2008, over 10% per member year that year, while the Massachusetts economy actually shrank. That gives you an idea of the magnitude of some of the issues that you have heard about already this morning.

This slide shows you not only the change in spending -- the growth rate in spending per member year by the kind of payer, by these three major payers, but also by major payer group. It gives you an idea of the complexity of taking these expenditure patterns apart and looking at who is spending what and how they align across payers. Overall, outpatient care and professional services drove aggregate spending growth in 2008. This was the story last year as well. Outpatient hospital care and payments for physician and professional services drove the majority of spending growth when we did the same kind of analysis last year. Private payers paid more -- the growth in private payments was greater than the growth in Medicare payments or in Medicaid payments for all of these service areas, except for prescription drugs. The private payers -- the growth in payments from 2007 to 2008 was over 10% for outpatient care, and 9.2% for professional services. Medicare spent substantially more also for outpatient and hospital care from 2007 to 2008, but the rate of growth was much less than for private pay. Mass Health also spent more for professional services in 2007 to 2008, but again, less than the growth in payment per member year for private payers. The shrinking of expenditures for prescription drugs from 2007 to 2008 was largely due to a drop in utilization, probably related to changes in insurance coverage for prescription drugs and

private policies. The large growth in payment for prescription drugs by Medicare was largely related to the phasing in of Medicare part D.

This slide gives you an idea of what happened to private insurance payments by service type, not only in 2007 to 2008, which you've just seen, but what happened then from 2008 to 2009, the growth that occurred in that last year. While the private payers sustained a much higher rate of growth than the public payers from 2007 to 2008, that bumped up tremendously in 2009. Inpatient hospital care bumped up 10%, but the big drivers, again, were the hospital outpatient and professional services. The growth in spending for those two service categories explained 84% of the total growth in private insurance spending from 2008 to 2009. That said, that 10.3% growth rate for inpatient care is problematic. It's just not of the magnitude of the other two service categories in explaining the total increase in spending from 2008 to 2009.

The outpatient spending growth that we observed from 2007 through 2009 in both years relates disproportionately to care received in outpatient departments of Boston area tertiary care hospitals. The blue bar in this slide shows you the percent of total spending in 2009, and the green bar shows you the percent

of the amount of spending change, the percent of total spending change, that those hospitals accounted for. While Boston area tertiary care hospitals accounted for 35% of total spending in 2009, they accounted for 42% of the growth in spending from 2007 to 2009. Specialty area hospitals also were -- spending in those hospitals grew disproportionately fast. They accounted for 11% of total spending, but 16% of total spending growth. The hospitals that represent a disproportionately small amount of the spending growth, you see at the bottom of this chart, which are community hospitals outside the Boston medical area.

For professional services, we've seen most of the increase in spending related to where most of the spending now occurs. This chart gives you, again, the percent of professional services spending in 2009, in the blue bar, and then the rate of growth in the green bar. Specialty physicians account for about 46% of total spending for physician and professional services in 2009, and the growth rate was 10.1% from 2008 to 2009. That's where most of the growth in total spending went, to pay for physician specialty services. We also saw a relatively high rate of growth in spending for other professional services, but as you see, they're still a relatively small proportion of total spending in that category. Inpatient spending was -- we looked at inpatient spending in particular because of that bump up in the

expenditures per member year for inpatient spending, from 2008 to 2009. Much of the growth in that category related to increases in admissions for medical stays, not surgical stays, where the growth rate in spending per member year was 13.5% from 2008 to 2009. You'll see that behavioral health spending grew very, very fast from 2007 to 2008, almost 50% increase, related largely to changes in federal and state law around mental health parity. That dropped down a bit from 2008 to 2009, and it may actually drop down a bit further in subsequent years. But that last category, despite the alarmingly high rate of growth, is still only 2% of total spending. It's not the largest category. The largest categories are surgical and medical, and the high rate of growth per member year spending, per medical admissions is probably where attention should be focused.

The increase in spending for inpatient care, as I said, with respect to outpatient services, relates largely to Boston area tertiary care hospitals. The increase in spending for inpatient care also relates disproportionately to those hospitals, simply because they represent where most of the care is obtained in Massachusetts. For private payers, if you add the tertiary care slice, in the upper left hand corner of the pie, with the specialty care slice, you will see that two-thirds of inpatient hospital care in Massachusetts is provided in tertiary care

hospitals. Again, when you are looking for where the cost increases -- from where they stem, they're going to stem largely from changes in cost in those hospitals.

We took a look at what was driving this growth pattern. Clearly, when you see an increase in the cost of anything, and including the cost of health care, several things can drive it. It can be volume. More services are being provided. It can be the price that each provider is charging. It can be a change in the service mix, the kinds of services that are being used. It can be, given the variation in pricing that you will hear about over the next few days, and have heard about already, it can be simply a redistribution among providers, because different providers are charging very different prices for the same service. We parsed all of those factors out to try to understand what was actually driving increased spending per member year. For private payers, it was largely higher prices. All of the growth, in effect, in inpatient hospital spending, in both 2008 and 2009, related to higher prices. This is not a movement. As I said, this is not a movement of patients among different hospitals. That was actually very stable. It was not a change in the service mix towards more complex services, or higher-cost services. Those were largely stable. When you look at an increase in the total cost of inpatient services, you are

largely looking simply at what we are calling a pure price increase for inpatient care. About half of the increase in spending for hospital outpatient care in 2008, and, in effect, all of the increase in 2009, was again related to that pure price effect. Not a change in the mix of services, not a change in the location of services; simply an increase in the price that was charged for the same service.

Professional spending was a little more complicated, but again, price was the largest driver there, explaining three quarters to almost 90% of the increase in spending in 2008 and 2009. We also saw price driving other service areas, in particular for branded prescription drugs. From 2007 to 2008, price was a very large driver. For generic drugs, we saw increases of about 2% in price. For the branded drugs, we saw increases in excess of 10% on average across that service category. Also, spending for diagnostic imaging services, you'll see in the report on the Division's website separate analyses for those. Again, price was largely the source of the increase in spending for those services. For Medicare and Mass Health, price was much less of a driver. These are, if you will, administered price systems. In the increases we saw for those payers related as much, if not more, to changes in utilization as to changes in price.

For Medicare growth in spending for outpatient hospital care and professional services, it was mostly or entirely due to greater service use, not to increases in price. For inpatient care in Medicare, there was an increase in the amount of services that were used, but the growth in total spending for those services was not like the growth in total spending in the private pay sector. I should say also that for Medicare and Mass Health, we did not do that price dis-aggregation, so we're really looking here at the volume of services provided and the payments per provided service. So for Medicare, the change in the spending per inpatient admission could relate to changes in the service mix for that population as the Medicare population in particular ages. For Mass Health, the spending for outpatient care actually declined as service use declined in that sector, and the growth in professional services spending for Mass Health related not to an increase in spending per service, but entirely to an increase in the number of services used as Mass Health introduced new populations into coverage over that period of time. So the stories are very, very different for private pay and for public pay. We are hopeful that the report will give you a place to start thinking about these issues. Thank you.

Seena Perumal Carrington

Thank you, Deborah. Thank you, Dianna. I'll ask now a few of the questions submitted by the audience members. You mentioned claims expenditures trended downward in 2010. Do you have any insight into why that occurred? Either of you.

Dianna K. Welch

I think what we've seen nationally, and one thing I can point to would be just the flu season, for example, being less severe than it had been in 2009, so that would result in a lower claim trend. I would also probably point people to some of the written testimony by the carrier. Some of them had very specific initiatives that they took on, either in pharmacy cost mitigation or just lower increases to providers that they pointed to as some of the reasons for them.

Seena Perumal Carrington

Thank you. Last year's report on trends in private plans showed a large increase in high-deductible plans, 1,000+, from less

than 4% in 2006 to 11% in 2008. What happened to enrollment in high-deductible plans in 2009?

Dianna K. Welch

They definitely increased. I don’t have hard numbers in front of me, but the graph that I showed that showed the actuarial value, those actuarial values that are in the lower ranges, like the .65 to the .7, or even the .7 to .8, that’s where the higher deductible plans are. When you see the small groups trending up very quickly into that .65 to .7 actuarial value range, that’s showing a lot more members going into those higher deductible products, at least in the small group market. I would suspect that a similar thing is going on in the midsize and large group markets, since we did see the overall actuarial value decrease. It just didn’t decrease quite as quickly or as sharply as it did in the small group market.

Seena Perumal Carrington

It seems the majority of these questions are for you, Dianna. How much of the 10.3% increase in private payer spending was related to cost sharing?

Dianna K. Welch

I'm sorry, I'm not sure I know what the 10.3 references.

Seena Perumal Carrington

I think it must have been the -- was it the increase from 2009 in private payer spending? How much of that was related to cost sharing?

Deborah Chollet

I think, in a sense, you may be asking how much of the 10.3 increase was increase cost sharing, and actually I don't have that number in front of me. I don't imagine that it was a much

larger share in 2009 than it was in 2008, essentially, but I can take a look at our numbers and get back to you on that if you need to know.

Seena Perumal Carrington

Lastly, why are the claims higher for small groups?

Dianna K. Welch

I can only speculate. We don’t have data that would tell us exactly why they are. What people will often point to is a little more potential for adverse selection in the small group market. In the large group market, where contributions tend to be higher from the employers, you often get a much broader cross section of risk, because even those lower-risk employees see value in taking the insurance, because it is more heavily subsidized by the employer, whereas, at times, in the small group market, the contribution from the employer may not be as high. The employer may have either close employees or their own health needs that drive a health purchase decision. There can be more adverse selection in the small group market.

Seena Perumal Carrington

Thank you once again, Deborah and Dianna, for your assistance in producing these analytical reports on behalf of the Division of Health Care Finance and Policy. I now want to turn to Commissioner Joe Murphy from the Division of Insurance, who will provide a review of their analysis, as well as activities related to Chapter 288. I also want to recognize Undersecretary of Consumer Affairs, Barbara Anthony, who just joined us. Thank you.

Joseph Murphy

Good morning. Thank you for having me here today. I'm joined at my place on the panel by Kevin Beagan, who is our Deputy Commissioner and heads up our health care access unit. As reflected in recent Division of Insurance and Division of Health Care Finance and Policy reports, health insurance premium increases here in the Commonwealth continue to outpace inflation. Despite this increase in premiums, more Massachusetts residents have insurance coverage than ever before, as a result

of our landmark health insurance reform legislation in 2006. Division of Health Care Finance and Policy premium trend reports have illustrated that premiums are rising for all individuals and employers, arguably at levels beyond the affordability of many Massachusetts residents. Administrative costs are rising, and are higher per person for small groups and individuals. They fluctuate from year to year, with new investments in spending. They are a declining portion of total premium dollars, as measured by medical loss ratios, as total health care dollars have grown. Medical loss ratios are increasing, except for a slight decline in calendar year 2010. The Division of Health Care Finance and Policy health trend reports have illustrated that health expenditures have risen dramatically since 2002. Private payers are being expected to pay higher service prices for certain services to make up for shortfalls from public payer rates of reimbursement. Utilization has increased for many outpatient services. Consumers are receiving more care from higher cost providers.

Over the past 20 months, the Division of Insurance has devoted significant resources to investigating the causes of these premium increases. It has collaborated with our colleagues throughout government and in the industry to address some of the issues contributing to these increases. In February of 2010,

Governor Patrick directed the Division of Insurance to amend its rate regulation rules to require health carriers to file their small group rates for Division of Insurance staff review, prior to using them in the market. Our amended regulation also required carriers to submit detailed information in support of these proposed rates. On April 1st of 2010, after reviewing these proposed rates, the Division of Insurance disapproved 235 of 274 small group health insurance rates that proposed to increase base rates by as much as 34%. As many of you know, in addition to these base rates, carriers can apply statutorily allowable group rating factors that can result in premium increases significantly higher than the base rate. The Division held administrative hearings on the disapproved rates during the summer of 2010, and entered into settlement agreements with carriers that eventually saved Massachusetts small employers and individuals $106 million below what the carriers would have received under the original proposed rates. Carrier small group rates for the first half of 2011 have increased, on average, by less than 10%. As July 1st approaches, carriers are preparing to file their proposed October 1st quarterly rates with the Division of Insurance for our review.

Chapter 288 of the acts of 2010 modified the rate review standards for small group health insurance. Following public

sessions we held at the Division last fall on the appropriate way to implement this law, the Division promulgated amended regulations on April 1st of this year. These regulations require health carriers to file their proposed rates at least 90 days prior to their proposed effective date. Pursuant to Chapter 288 and this amended regulation, the Division will presumptively disapprove small group rates if the projected medical loss ratio for the small group products is less than 88% in 2011, or 90% in 2012. The standard reverts to the federal medical loss ratio standard in 2013. We will presumptively disapprove rates also if the contribution to surplus, or profit loading, is greater than 1.9%, or if the administrative expense loading increases by more than medical CPI for the northeast region. The Division will also disapprove small group rates if the benefits are unreasonable in relation to the rates charged, if the rates are excessive, inadequate, or unfairly discriminatory, or if they do not otherwise comply with legal or regulatory requirements.

By regulation, the Division required that July 1st, 2011 rates also smooth rate factors to reduce the relative impact when employers' covered members get older, and also implemented a rate bumper that limited changes in an employer group's employee census to impact rates by no greater than 15%. Chapter 288 further addresses open enrollment issues that led to abuses in

coverage for those who would buy coverage only when they needed medical procedures, and drop coverage when they did not. Under recently promulgated division regulations, health carriers that intend to offer limited or tiered network products are required to follow certain procedures to notify providers about the products and give them the right to opt out of participation in a product before it is filed for approval at the Division of Insurance. As these products have been popular in many other states, but not, to a large extent, here in Massachusetts, health carriers are to take steps to use appropriate consumer disclosures and marketing materials, enrollment applications, provider directories, ID cards, and summary materials, to inform consumers who do purchase these limited network products that the network of providers is not the same as available under the general network product, and about the process they use to tier these products. Small group health carriers that cover more than 5,000 eligible small employers or individuals are required to offer limited or tiered network products to eligible individuals and small employers in the largest metropolitan region in the carrier service area, that cost at least 12% less than the carrier’s most actuarially similar non-limited, non-tiered network product. These products are to be available for offer in the fall of 2011.

Chapter 288 of the acts of 2010 amended a longstanding provision in the Massachusetts market for small group health coverage. This provision prohibited small employers from joining together to negotiate rates with carriers. The Division recently promulgated regulations that facilitate the creation of up to six group purchasing cooperatives that can offer coverage to members of qualified associations that have contracted with the cooperative. Between August 1st and August 15th of this year, organizations which would like to apply to be a small group purchasing cooperative may submit applications to the Division of Insurance. These applications should illustrate their plans to contract with certain associations, develop wellness programs for association members, and manage the operations of the association. The Division will certify up to six of these group purchasing cooperatives in the fall, based on the ability to serve the diverse needs of employers here in Massachusetts. Once a group purchasing cooperative has been certified by the Division, it can require the state's small group carriers to respond with product that meets its own benefit design. The rates charged are to be based on those charged outside the group purchasing cooperatives, but rates may be adjusted according to the projected experience of the group purchasing cooperative. Group purchasing cooperatives are limited by law to cover only 85,000 covered lives in aggregate, and are required to enroll at

least 33% of its association members in sponsored wellness programs.

Chapter 288 requires health carriers to submit detailed supplemental financial reports that provide additional detail on carrier administrative expenses, based on the different types of product in small group and large group markets in which the products are offered. The Division recently promulgated a regulation that delineated the specific material that is to be forwarded by carriers annually so that the Division can produce an aggregate report. Information based on 2010 financial data is to be submitted by September 1st of this year. It is to be submitted in all other years by April 1st. The Division will produce an aggregate report in 2011 by October 15th. The Division also promulgated a regulation that requires third-party administrators to register with the Division and to submit the same information as carriers must provide in their new annual financial reports. Like carriers, third-party administrators must file their 2010 financial data by September 1st. Thereafter, it will be submitted annually by April 1st.

The combined efforts of agencies throughout the Patrick and Murray administration have provided some immediate relief from sky-rocketing health insurance costs for individuals and small

businesses. However, more must be done. As illustrated through recent reports, health claim costs continue to rise at alarming rates, without a corresponding increase in quality or outcome. The May 2011 Division of Health Care Finance and Policy report details that medical loss ratios, calculated across all insured market sectors, increased from 88% to 91% between 2007 and 2009, reflecting the need to impact the cost of care to impact premiums. Under legislation recently filed by Governor Patrick, the Division of Insurance would have increased authority to deny insurance rates of carriers which have negotiated excessive rates of provider reimbursement. The Division would base its review of the level of rate increase on the following criteria: the rate of increase in Massachusetts gross domestic products; the rate of increase in total medical expenses; a provider's rate of reimbursement with a carrier, especially in relation to the carrier's statewide relative average price; and whether the carrier and a contracting provider are transitioning from a fee-for-service contract to an alternate payment contract. This legislation would encourage the formation of integrated care organizations, commonly referred to as ACOs, or accountable care organizations. These would be certified by the Division of Health Care Finance and Policy. The proposed legislation would authorize the development of standards for ACOs and direct the Division of Health Care Finance and Policy to regulate

alternative payment methodologies, including global payments, that would be used in contracts between payers and ACOs and other providers. Under the proposed legislation, the Division of Insurance would establish financial oversight regulations that would apply to ACOs and providers who take on greater levels of risk from carriers and other parties. The legislation also includes coordinating an advisory council to oversee planning and implementation.

This legislation, as discussed earlier, is currently before the Joint Committee on Health Care Finance, and the subject of public hearings throughout the Commonwealth. We look forward to working with our partners in the legislature to pass meaningful cost containment legislation this session. This concludes my comments for today's hearing. Deputy Commissioner Beagan and I would be happy to entertain any questions. Thank you.

Seena Perumal Carrington

I can just ask a few questions from here, if you don't mind, Commissioner. How will purchasing cooperatives impact the cost of health care?

Joseph Murphy

The purchasing cooperatives, as we heard through the public hearings and public sessions we've held over the past 18 months -- we've heard from large employers that are able to offer these types of wellness programs to their employees, not so much for small employees. The wellness component, hopefully, will drive down utilization by encouraging a healthier workforce population.

Seena Perumal Carrington

When will less expensive tiered and limited network products be available?

Joseph Murphy

Under the regulations, we recently promulgated those products. We hope to have this fall. Kevin, if you have anything.

Kevin Beagan

Many companies are actually going through their re-contracting right now to develop products that will be available through the metropolitan areas. We know that companies have indicated to us that they're looking to have the 12% cheaper products available, either in early fall or by as late as January 1st. Those products are required to be offered to all eligible employers that have one to 50 employees, as well as to individuals.

Seena Perumal Carrington

How does federal health reform impact Massachusetts?

Joseph Murphy

As we're all well aware, the federal reform is based loosely on the Massachusetts model. Secretary Bigby, one of the many sessions in meetings she hosts is a regular meeting with the cross section of administrative agencies within and throughout government that impact health reform. Her team is coordinating the various aspects that we need to change here in

Massachusetts, things like the fair share of contributions, that I know you're well aware of. We're well ahead of the rest of the country. I can tell you, attending the National Association of Insurance Commissioners, Kevin Beagan is in hot demand for other states looking to implement health reform. We're well ahead of the rest of the nation. We've got some grant money that we're using to continue our rate review process as well.

Seena Perumal Carrington

In the Division's analysis of medical loss ratio, it was calculated using the traditional sense, and I know that's been recently revised. Could you just provide some specifics on what that change was?

Kevin Beagan

Traditionally, medical loss ratio has usually been a calculation that looks at just payments to providers, divided by premiums collected. There has been a great deal of analysis done on the federal level, especially coming out of the ACA, to also factor in additional administrative costs associated with claims

payment, and also with quality improvement programs. The Division of Insurance did promulgate regulations that piggy-backed off of the federal regulations. Our goal is to make sure that we're able to present medical loss ratio information consistently across all companies. I think that the numbers presented by the Division of Health Care Finance and Policy in their reports are very similar to what we will see when we get our final reports. Our reports are due to be sent to the Division of Insurance in April 2012. I don't think you'll see appreciably different numbers. The reason it's important that we at the Division do include our reports with the federally calculated medical loss ratio -- there is a requirement that companies that fall below the required medical loss ratio make refunds to those small employers who are actually covered under plans where they were actually in a plan below the medical loss ratio. So it's important, between April and July of next year, that we very carefully go through all the medical loss ratio calculations and determine how certain health carriers may have to make refunds back to employers based upon the standardized federal MLR standards.

Seena Perumal Carrington

Thank you, Commissioner Murphy and the Division of Insurance team. We'll actually take a short break for approximately 10 minutes or so. The Governor is scheduled to arrive --

END OF AUDIO FILE

Seena Perumal Carrington

A man who's vision, leadership, and strong belief in generational responsibility has placed the Commonwealth on the path to tackling health care costs. The Governor of the Commonwealth, Deval Patrick.

Deval Patrick

Good morning, everyone, or good afternoon. I hope I didn't keep you waiting too long. Thank you so much, Commissioner, to you, to General O'Brien, to -- we have all kinds of Commissioners here today -- to all the Commissioners, to all the members of the panel. Thank you for convening this series of hearings and for inviting me to be with you. The cost of health care, as

everyone here knows, is going up at an unsustainable rate, both in Massachusetts and all around the country. Controlling those costs is an urgent challenge for small businesses, working families, and governments everywhere. Failing to do so will threaten our economic recovery. Today, we have an opportunity to discuss some of the solutions to this challenge, so I would like to focus my testimony on some of the cost containment strategies that we have put on the table.

First, where are we today? As you all know, Massachusetts leads the nation in health care coverage for our residents. Thanks to our landmark health reform bill that passed in 2006, over 98% of our residents have health insurance today, 99.8% of children. No other state in America can touch that. I'm very proud of it. You ought to be as well. More private companies offer their employees insurance now than before the bill was passed. People no longer have to fear having their insurance canceled when they get sick and need it most, or that a serious illness will leave them bankrupt. It's affordable, having added only about 1% of the state budget to state spending, and it stands as a value statement, that in Massachusetts, we believe health is a public good and that everyone deserves access to it. That reform was not an end in itself. In the first place, it was a marker we put down about what kind of community we wanted to live in.

That’s why a broad range of interests, including many of you here today, came together to get a good bill, and then stuck together as we worked to implement and refine it, even in the face of the worst economic collapse in living memory.

In the second place, cost containment was largely put off to another day. Now it’s time for that broad coalition to come together again. Health insurance premiums continue to increase at an unsustainable rate. The Division of Health Care Finance and Policy’s recent reports, as well as the many written testimonies submitted in advance of this hearing from providers, health plans, businesses, consumers, and policy experts from around the Commonwealth make that abundantly clear. This is not a challenge unique to Massachusetts, and it has nothing to do with our 2006 reform. Premiums increased across the nation, on average, 130% over the last decade. A state that has -- in Mississippi, a state that has no public commitment to universal care, their premiums have seen an increase of 113% in the same period. The point is that across the nation, just like across the Commonwealth, working families, small businesses, and governments alike are being squeezed every year by ever-higher premiums.

In the first phase of reform, we were about reaching the 400,000 or more uninsured. This phase has to be about relief for all 6.5 million Massachusetts residents. I meet many small business owners all across the state who see their commercial activity picking up these days and are ready to start hiring again, until they get handed their annual health insurance premium hike. I've yet to meet a business owner in the state, especially a small business owner, who doesn't see health care costs as a significant impediment to adding jobs. With small businesses making up 85% of the businesses in this state, there is an unyielding economic truth we have to face. If we don't start hiring, we don't get a recovery. They cannot start hiring unless they get a break on their health premiums.

The challenge before us is big, but we can't be defeated by the complexity of it. We have solved problems like this before, and with the help of the people in this room and the other witnesses appearing over the course of these hearings, we will get there. The good news is that there's an emerging consensus about solutions. By most accounts, higher quality care, meaning better integrated, whole person care, equates to lower cost. Instead of the fragmented fee-for-service system we have today, we ought to pay for what works. Paying for that kind of care will encourage different kinds of behaviors in the delivery of care, with the

added benefit of restraining cost increases. The legislation that we have proposed gives us some new tools to get there. Secretary Bigby and Secretary Gonzalez, I understand, have already outlined much of what we are proposing. I want to emphasize just a few points.

One of our strategies is to build on innovations like early stage accountable care organizations that are being tested in the market right now, and to bring these up to scale. Blue Cross Blue Shield, Tufts, Harvard Pilgrim, and other health plans, in partnership with providers like Mount Auburn Hospital and its physicians, physicians in Lowell and Hamden County, and Mass General, are testing new payment models and creating more integrated care settings right now. Our remarkable network of community health centers has long been a model for preventive and primary care in lower-cost settings. There are lessons to import from similarly innovative delivery models at work elsewhere in the country. These are all good first steps, but we need to scale them up in a responsible, comprehensive way to see the savings we need. As we do that, our legislation calls for the formation of a common set of expectations and standards to hold these organizations accountable for achieving better care at lower cost. We intend to prescribe the framework that will get us there. Under our plan, integrated care organizations and

insurers that pay for healthy outcomes, not just the volume of service, will predominate in our Commonwealth by June 2015. Once we get there, we will make sure that the savings are passed onto consumers and patients in the form of lower premiums. ACOs will be a part of this solution, but they are not the only part of the solution.

In the interest of urgency and accountability, we have proposed a variety of other measures, some new and some renewed, that also go after the cost conundrum from a variety of angles. One of those is direct government intervention. When the insurance Commissioner began disapproving proposed premium increases last spring, many objected. But after years of asking and even cajoling, it was the only option we had, and the fact is, it worked. That disapproval lowered rates and saved small groups and individuals more than $100 million. It also jumpstarted the movement we now see in the industry towards integrated care. The Division of Insurance Review remains a valuable and a necessary tool to protect small businesses and individuals. The language in our bill makes the authority of the Commissioner more explicit to consider all of the relevant criteria, including whether contracts have excessive provider reimbursement rates, in deciding whether to disapprove excessive premium increases. We must make certain that as we change the

way we pay for and deliver care, we don’t lock in the inequities in reimbursement that exist today.

The goal is not to punish any part of the industry or to return to the days of price regulation. I believe that everyone in the Massachusetts health care industry is sincere in their efforts and desire to deliver lower-cost and better health care. The goal of this proposal is to keep the pressure on all of us, including the state, to move as fast as we can to bring to consumers the cost savings we need to keep our economy growing. We have a moment here to share responsibility to bring premiums down, and we need to seize it.

There are parts of the bill that have not gotten as much attention: health resource planning, ensuring that the resources and services are matched to community needs. We can do a much better job at anticipating the health care needs and the health care workforce of tomorrow, and as a result, provide care in a more efficient, cost-effective way. There’s work we’ve already done, allowing small businesses to buy insurance through cooperatives and piloting limited and tiered provider network plans through our state health insurers. We project savings in excess of $20 million this year alone through the state GIC by encouraging more employees to seek care in less costly but high

quality networks. There's a real difference -- that's a real difference on the state level, one that we hope cities and towns will soon be able to enjoy after municipal health reform legislation is passed.

Taken as a whole, these measures make up the next phase for health care reform in Massachusetts. The details may be complicated, but as I said, we cannot be defeated by that complexity. Higher quality, well-integrated, whole person care means lower cost. From now on, we propose to pay for that, rather than the fragmented system that we have today. That's where we're going, and we need to get there quickly, and these hearings help.

Lastly, I want to leave no doubt about one thing, and I make this point whenever I'm with folks in the industry, because I have said before, you parse every word I say the way the Greeks used to read the entrails to forecast where we're going. Let me be absolutely clear: we are moving. We are moving. Change is coming. It will happen. We are not going to let inertia or complexity, or either the power of or high regard for the medical industry, to stand in the way of relief for working families and businesses. We need the legislature to get me final legislation for signature this fall, because the cost trends

that we are discussing today are about more than numbers and datasets. They are about people and their most urgent needs. Our communities and our neighbors need us to do more, and it's up to all of us to deliver. We led the nation to the most successful model for universal coverage ever. If anyone's going to crack the code on cost containment, it will be we here in the Commonwealth of Massachusetts. With your help, your learned study, and your constant urging, we will get this done, and get it done right. Thank you very much for having me.

Seena Perumal Carrington

Thank you, Governor. As I mentioned at the beginning, there are no easy answers to the challenge of rising health care costs, but your commitment to providing relief to Massachusetts residents and businesses is inspiring, so thank you again for joining us today. You've reminded us -- he reminded all of us of the urgency of these proceedings, and basically the call to action that we must all heed in order to identify strategies to contain health care costs now, not tomorrow. Before we go to the next segment of our agenda, I just want to give you sort of what the next steps will be. Basically, we're now going to have lunch for about 45 minutes or so. We'll reconvene at 1:15 PM. There is

a café and cafeteria located on the first floor. At 1:15, the Attorney General’s office will provide their analysis on health care cost trends and drivers. There is also a public testimony period at 2:15, and for those who are interested in providing comments, there’s a signup sheet at the front desk, at the registration table. Hopefully, as I said, if we can keep the schedule for the remainder of the afternoon, we should be done before 5 PM. Thank you.

END OF AUDIO FILE